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Pragmatic Acculturation and Health: Production and Utilization of Ágbó in South-Eastern Nigeria

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Abstract

Pragmatic acculturation is increasingly becoming a global phenomenon particularly in the health sector. It is evident among providers and users of traditional herbal tonics in Nigeria involving inter-cultural/ethnic herbal exchanges. Agbo is a traditional Yoruba herbal and root remedy believed to cure a lot of ailments like malaria, sexually transmitted infections, and infertility issues, stomach upset, menstrual cramps, back aches, among others. This herbal remedy initially produced by the Yorubas is now produced and utilized by other ethnic groups in Nigeria mainly because of its capacity to meet the health needs of all class of people and for its affordability and availability. This is an ethnographic study which employed participant observation, key informant and in-depth interviews anchored on Stella Quah’s ideas on pragmatic acculturation to ascertain why this cultural borrowing and transformations, who are the producers, distributors and users and what is its implication for health of Nigerians? Findings reveal willing and conscious migration and borrowing otherwise known as pragmatic acculturation as the main reason. Other factors are failure of the Nigerian health system to meet health needs of all especially the poor, subjective beliefs about biomedical drugs, ignorance, and low level of health education among others. Study recommends a re-evaluation of the primary health care policy, regulation of traditional herbal practitioners and proper health education of the Nigerian populace on the negative impacts of pragmatic acculturation on health.

Key words: Pragmatic acculturation, agbo, health education, herbal remedy, health risks.
Introduction

There has been increasing consciousness on the acculturative implications of modern inter and intra country migrations as well as the effects of globalization on human health across the world. Africa is also not left out of these externally and internally driven influences and changes which has remained an inevitable reality in Africa since the late 18th century as a result of European expansion and colonization (Onwuka, 2002). Africa experienced all kinds of unsolicited acculturation. This led to alterations in existing social structures, social institutions, customs, values, norms, dress and dress patterns, ethno-medicine, and other cultural practices of natives. There were/are partial and impartial changes in general ways of life of the people in the African continent due to externally and internally driven culture contacts and borrowing. However, following the political independence gained from the 1950s-1960s and with the increasing spate of globalization and willful migration, Africa and Africans is/are now experiencing what we will call ‘pragmatic acculturation’; within and without the continent. This is arguably fuelled by the forces of globalization and to some extent by acculturation. Both concepts talk about change but globalization is a special kind of change (Ritzer, 2010). Globalization is a process that interconnects individuals, and social groups across specific geopolitical borders, creates new social identities and relations, allows for increasing multidirectional flows of people, objects, places, and information (Ritzer, 2010). On the other hand, pragmatic acculturation according to Quah, (2001, p. 26) is “the process of culture borrowing motivated by the desire to satisfy specific needs”. One area which conscious culture borrowing has become significant is in the health sector. The excerpt below properly captures the concept of pragmatic acculturation:

Pragmatic acculturation refers to “the cultural system of behavior and attitudes that allows and often encourages culture-borrowing or the adoption of aspects of non-native cultures for the purpose of satisfying specific needs” (Quah 1989, p. 6). It refers to a person's or group's borrowing, ways of thinking (ideas) and ways of doing things (procedures) from other cultures to solve specific problems. Pragmatic acculturation is usually but not exclusively found in ethnically plural societies and it is conceptually different from acculturation or assimilation usually defined as “the process by which an outsider, immigrant, or subordinate group becomes indistinguishably integrated into the dominant host society” (Marshall 1996, p. 20; Kovacks & Cropley, 1975, p. 10). In contrast to acculturation, the notion of “culture borrowing” in pragmatic acculturation is more than just a “movement of things among societies”; it encompasses patterns of behavior and attitudes. The concept pragmatic acculturation in comparative sociological research contributes to an effective understanding of the permeability of cultural boundaries and its effect on various aspects of social life; of the permanent or temporary transformation in belief systems; and of the
way cultural beliefs and norms influence accounts of social life processes and events such as work productivity, governance styles, or disease incidence….(Quah Stella in Ritzer, 2007).

Prevalence and incidences of diseases in a population arguably accounts for pragmatic acculturation in the health sector. Again, Quah (2008, p. 419) observed that “amidst the existing pluralistic healing and curative options available to people, one thing predominates: people do cross cultural boundaries in search of cure and this is conceptually known as pragmatic acculturation”. This refers to borrowing of ideas, ways of thinking and ways of doing things that is not your own. Here, the individual may borrow these curative remedies with or without adopting or believing in the cosmology and philosophy behind the healing system.

From the above conceptualizations, alterations and changes in a given culture is now a conscious and willful necessity in the 21st century and not an imposition as observed in the colonial era. Acculturation has been variously conceptualized by scholars from various lenses and perspectives. McLachlan (1997, p. 37-42) posits that “acculturation refers to the process of transition which is brought about by the meeting of peoples from two different cultures”. Such a transition may occur in either one or both, of the cultures. This process normally ensures that the migrant becomes totally and indistinguishably integrated into the dominant host. With pragmatic acculturation the migrant seems to remain or maintain a distinct or different identity from the host and in some cases exerts greater influence and dominance on the host community. This is evident in the increasing internationalism and multiculturalism prevalent in the 21st century both in complex and simple societies, as there are no isolated societies existing anywhere in the world without intra and inter or cross-cultural contacts. Helman, (1990, p. 3) observed that “most modern complex societies have continued to have influx of divers religious and ethnic minorities, tourists, foreign students, political refugees, recent immigrants and migrant workers, each with their distinctive cultures, traits and identities”. Many of these migrants may arguably undergo some degrees of acculturation whereby they adapt or incorporate some of the cultural attributes of others, and as such creating subcultures within the larger society. McElroy and Townsend, (1989, p. 297) explained that “acculturation is a type of change which involves continuous contact between two previously autonomous cultural traditions, usually leading to extensive changes in one or both systems”. MacLachlan, (1989 citing Berry and Kim, 1988) had
identified different types of acculturative experiences namely integration, assimilation, separation and marginalization.

With the current significant inter and intra continental, regional, ethnic or societal acculturation going on since the end of colonization, profound changes and alterations has been remarkably evident in the cultures of various countries in the world, specifically Africa has continued to experience its impact and Nigeria is not left out. This implies that change must not necessarily come from external forces as certain changes could be triggered from within or internal forces. Helman, (1990) highlighted that Anthropologists such as Leach (1982) have pointed out that virtually all societies have more than one culture within their borders. Nigeria being a vast country geographically and in material and human resources has also continued to experience inter and intra-societal migration and acculturation. Nigeria is arguably one of the most populous black nations in the world, with over 140 million people based on the 2006 census figures and occupies an extensive land mass of 923,768 square kilometers (Aremu, 2008). The ethnic groups are numerous and they include Yoruba, Hausa, Igbo, Kauri, Fulani, Tiv, Idoma, Istekiri, Efik etc, (Ogundele, 2007). It is endowed specifically with over 250 ethnic groups with their distinctive languages and cultures in the six geopolitical regions that make up the country. As Nigerians and non-Nigerians living within the country, people are constitutionally free to explore, migrate and even settle in regions outside their localities. As such, it is common for one to see any of three major ethnic groups- Igbo, Hausa, Yoruba and other minor ethnic groups living in other areas outside their indigenous settlements, due to unrestricted migration as enshrined in the Nigerian constitution. But it is pertinent to highlight that these migrants within Nigeria do not just move alone, they go along with their cultures consciously and unconsciously transmit their values and practices to the host cultures. Migration therefore necessitates culture contacts within countries and this to a large extent results to pragmatic acculturation. This study intends to highlight the fact that these current 21st century migrations are not done under duress, but it is a conscious and willful movement necessitated by the need to explore other parts of the country and also to meet specific needs. These needs are mostly economic in nature and not only necessitated by health needs and as people move, they go along with their cultural practices. This is what this article arguably calls ‘pragmatic acculturation’ which occurs not just from mere forced migration but from a willful and conscious migration and borrowing in a bid to satisfying specific needs which
permeates all spheres of human life such as health care, economy, education, culture, politics among others.

This paper is therefore set to explore the patterns and reasons for pragmatic acculturation, implications of pragmatic acculturation on human health with particular reference to the production and utilization of a south-western Yoruba herbal remedy now produced and utilized among the Igbos in south-eastern Nigeria. This study also argues that forceful imposition of other cultural values and practices has declined or has been totally eliminated with the end of colonization, but what is conspicuously taking place now is pragmatic acculturation or what we may call “conscious or willful borrowing” of cultural practices from other places for the purpose of meeting specific needs. These willful borrowings from other cultures are necessitated by several factors. However, it is pertinent to point out that pragmatic acculturation is not exclusively beneficial but sometimes has some negative consequences, maybe due to the issue of adaptability. The capacity to adapt a borrowed cultural item necessitates and justifies any pragmatic acculturation. Pragmatic acculturation therefore takes place especially at the micro-level of the users and producers if it has been proven beyond every reasonable doubt that its adaptation enhances survival and health. This is necessary because the health problems of acculturation are many, ranging from poor nutrition because of changes in diets to the emotional stress of political or economic subordination faced by minorities such as migrants, and to exposure to new hazards in the new environments where migrants find themselves (McElroy & Townsend 1989). Hence, the need for pragmatic acculturation which enables conscious, willful borrowing after proper assessment and testing of the cultural item being borrowed. For instance, Nweneka, Tapha-Sosseh and Sossa (2009) observed that anecdotal evidences shows that many traditional healers in parts of Africa add antibiotics to some of the concoctions they administer to their clients. This is purely pragmatic acculturation at play. Quah (2008) explained this behavior by asserting that preventive health behavior is one of the factors that fuels pragmatic acculturation particularly by people who consider themselves healthy and wish to avoid illness; these individuals often combine biomedicine such as vitamins with traditional herbal tonics. Similarly, one prominent health problem endemic in Nigeria is malaria which is often propagated by the female anopheles mosquitoes. Malaria is locally known by different names across the various ethnic groups in Nigeria. Malaria is known as ‘iba’, among the Igbo and Yoruba, ‘zazzabin chizon sauro’ in Hausa, ‘zazzabi bu amoi’ in Jukun and ‘uto enyin’ in Ibibio/Efik.
languages respectively. The prevalence of malaria in Nigeria is one of the factors that has given rise to and perpetuated the production and utilization of traditional herbal remedies. These malaria herbal remedies come in diverse forms and shades as produced by multicultural groups. Each cultural group prior to the advent of modern biomedical discoveries has evolved traditional medical expertise in curing and treating malaria and other diseases. One of such primordial ethno-medical herbal remedies for malaria and other diseases is *agbo* initially known, produced and utilized among the Yoruba ethnic group of south western Nigeria. However, this same herbal remedy has been borrowed, produced, and utilized by Igbos and other ethnics in south eastern Nigeria. This necessitated the interest and need to probe:

- Why this cultural borrowing?
- Who are the producers of this herbal remedy in south eastern Nigeria and?
- What are the implications of this herbal remedy on health in south eastern Nigeria?

**Study Methodology**

This paper is based on the qualitative ethnographic study carried out in Awka, Anambra state Nigeria. This ethnographic research approach was employed because it affords the study the opportunity and benefits derived from the utilization of a variety of methods such as participant observation, in-depth interviews, and key informant interviews. Multicultural samples of 20 respondents involving the Yoruba cultural group and the Igbo cultural group among other ethnic groups were purposively selected and interviewed. The producers/sellers (mainly 10 migrant Yoruba ethnics) of ‘agbo’ herbal remedy served as key informants while in-depth interviews were conducted on the users (majorly from 6 host Igbo ethnics and 4 others) of this herbal remedy. These methods were balanced with ethnographic participant observations to validate data collected from the interviews. The researcher constantly visited the producers in their homes, as most producers and sellers were randomly co-opted into the study immediately the researcher sights them carrying and hawking bottles of their herbal tonics in basins, they are immediately approached to participate in the study. Their home addresses were collected after which the researcher visits them in their homes for proper in-depth interviews. The users were often met in the homes of the producers cum sellers and were also interviewed. Some other users of this traditional herbal remedy were gotten through the application of snowball technique.
Some of the producers/sellers linked the researcher to their users or buyers. The above primary data collection procedure was complimented with secondary data derived from consulting relevant texts, journals and periodicals were necessary to ensure a holistic analysis of the study interest.

Data was recorded with electronic gadgets which was later transcribed and analyzed using manual content analysis. This involved sorting, editing, thematic categorization based on research objectives to enable systematic extrapolations to be made.

**Findings**

**Why the cultural borrowing?**

*Agbo* is a traditional herbal remedy mainly produced and utilized in Nigeria by south-western Yoruba ethnics but in recent times has been adopted or borrowed by other ethnic groups and particularly the Igbo of south eastern Nigeria is not left out. *Agbo* according to 70% of the respondents (who were mainly Yoruba producers) means ‘root, medicine, or herbs’ but the nomenclature differs among residents as narrated by this respondent.

For the *Igbo* users, *agbo* is “*Ogwu ndi Yoruba*” meaning “*Yoruba* traditional medicine” while some other *Igbo* users call it *Igbo* traditional medicine” while others simply called it traditional medicine (Personal interview, male producer, 20/7/2013).

This raises the necessity to probe the concept of being “traditional” in the process of pragmatic acculturation. Whose culture (host or the migrant) is the item being borrowed referred to as being traditional? This is necessary because Quah (2003, p. 2000) had observed that “current research works on systems of healing fall generally into two main domains namely biomedicine and non-biomedical healing systems which includes that which is traditional to a society”. Does the concept of being traditional refer to all healing systems involving non-biomedical system or does it mean that which is autochthonous to the transmitter or that which is indigenous to the borrower/user? These probes bring to fore the complexities and intricacies involved in the process of pragmatic acculturation. These complexities arguably play a role in the social psychology of acceptance and utilization of herbal remedies by the recipients. The *Igbo* users who called this *Yoruba* herbal remedy an *Igbo* traditional medicine seem to have done so in order
to provide psychologically logical justification for its utilization. Thus, personalization of a borrowed cultural item enables user to embark on pragmatic acculturation.

Furthermore, the study found that the use of agbo in south eastern Nigeria is a conscious cultural borrowing done solely to meet specific health needs which these users/borrowers perceive modern biomedicine could not meet and this is what we may call pragmatic acculturation. This is properly captured by this respondent who is the husband to a female producer from Osun state south-western Nigeria and have resided in Anambra state south-eastern Nigeria for over 15 years;

Agbo is a Yoruba herb which has been adopted by other ethnic groups because of the failure of Nigerian government to provide cheap or affordable drugs to citizens. The Easterners got the knowledge about the herb from us (Yoruba migrants) and they started using agbo when they tested the herb we produce and found out that it was highly effective in treating a lot of diseases. They (Igbo) now prefer ‘agbo’ to biomedical drugs. (Persona Interview, 13/06/2013).

Another reason encouraging people to take these traditional herbal health remedies is that most respondents detest the ‘structure, form and taste’ of biomedical drugs as they find it difficult swallowing modern drugs in capsules or tablet forms, so they prefer liquid herbs like this respondent.

For me, I hate Oyibo (Whiteman’s) medicine, it is always difficult to swallow, most of them are very bitter and they make me vomit all the time. So I prefer traditional medicine! (Personal interview, female user, 20/06/2013).

This to a large extent may arguably not be a cogent and acceptable reason since modern medicine or drugs also exist in liquid forms. It then means there is more to this preference for traditional herbal liquid remedies than an ordinary eye could decipher. This dislike could stem from people’s perception of biomedicine as something foreign from the natives. Though, Quah (2003) had referred to biomedicine as the practice and substance of the ‘western tradition of healing’ from the early period generally known with diverse terminologies but recently known as Hippocratic medicine. It is pertinent to point out that modern health care systems have for a long time taken little or no account of what the patients think about their health and where they prefer to go for treatment. In spite of the efforts by the Nigerian government to discourage people from
taking unscientifically certified traditional herbal remedies through its regulatory agency National Agency for Food and Drug Administration Control (NAFDAC). This kind of cultural-borrowing continues to persist among Nigerians. This also reveals the continued prevalence and preference for self medication over prescribed medication. The continued mixture and usage of biomedicine and traditional herbal remedies persists. This arguably is an inevitable consequence of medical pluralism across modern societies as there are no isolated societies who had not had one form of culture contact or the other. The powerful influence of globalization may account for this but the persisting recourse to the use of traditional herbal tonics may imply that globalization is/may not be that powerful after all. In essence, there seems to be a mismatch between the kind of health remedies provided by the biomedical health care systems and where and what people actually opt for in the event of diseases and illness. Quah, (2003, p. 2001) observed that “across ages, a natural response to illness or injury is to seek healing. The search often takes the affected person from his immediate circle of relations to more distant potential sources of help until something that works or someone who knows is found”. This researcher met with a female user who traveled from Ekwulobia to Awka in search of herbal remedies and she has this to say

I have been having fertility issues and I heard that is mama agbo’s traditional medicine cures this problem and that is why I traveled from my town to this place to buy from her. I have friends who said the herbs works for them, so let me try and see (Personal interview, Female user, 16/17/2013).

There is also need to understand the dynamics of the utilization of traditional and biomedical health care services In order to make health care provision policies responsive and sensitive to the consumer (patient) preferences (Ngetich, 2008). There seems to be indeed ‘specific needs’ which modern biomedicine is not meeting and this the central import enunciated through the concept of “pragmatic acculturation”. Ellen (2010, p. 18) had argued that “biomedicine’s global dominance in public health, biomedical diagnosis and rational biomedical behavior cannot simply replace existing ways of understanding and coping with illness”. This is not surprising as existence of both health systems (traditional and biomedicine) has given credence to this type of comparison, in spite of the negative effects of using traditional medicine enunciated by health professionals. This may arguably be true due to this reason asserted by Ngetich, (2008, p. 28) that “traditional medicine has continued to maintain its identity and vigour because it forms part of a people cultural heritage, resulting in the parallel co-existence of traditional and modern
health care systems”. One specific reason for this continuity is that most herbal tonics perform dual functions as curatives and stimulants.

I prefer traditional herbs because it performs double functions of keeping me high, you know quick action and at same time curing ailments (Personal interview, male user 16/6/2013).

We men always take traditional medicine because it is very powerful and active, it can charge you up very well and keeps one high especially paraga. These herbs energizes you to perform very well during sex (Personal interview, male user 22/06/2013).

This is because these males rather than use water prefer local alcohol/gin as solvents for these herbs. However, it must be pointed out that once alcohol is used to ferment these herbs and roots, it is no longer agbo but paraga. Paraga is a Yoruba herbal remedy containing local herbs and gin/alcohol claimed to be effective in the treatment of piles, backaches and male erectile problems” (Ajala and Omobowale, 2013, p. 149). Paraga is mostly taken by men involved in hard strenuous works/jobs. Culture frowns at women who take paraga.

It is mostly men that take paraga, our culture does not permit women to take it but some women do take it in secrete not openly. I don’t know why some of these women take it but all I know is that it is not good for women to take paraga because it is quick action (Male producer, 22/06/2013).

Could it be true that modern biomedicine cannot meet the needs of people by serving as both curatives and stimulants? This leads to reasoning, in relation to healthy living; does the human body actually need drugs performing this dual function in one drug? These questions require further research in order to proffer proper answers.

Furthermore, the study found that economic and subsistence factors such as affordable prices as well as the financial proceeds from selling agbo herbal tonic, arguably maybe another reason for this cultural-borrowing and as such the producers keep propagating and advertising its use. A producer popularly known as ‘Mama agbo’ said;

agbo is made popular by ‘word of mouth’ and we have so many people selling agbo in this state and there is an association of agbo sellers in the state. When I hawk, I make over 2000 naira daily, moreover a lot of people come to my house to buy agbo, especially women having infertility and infection issues because it is effective and cheap (Personal Interview, Female producer, 24/7/2013).
Most of the respondents believe that traditional herbal remedies are cheap and there are no consultation fees and other bottle necks as seen in biomedical health systems as narrated by this primary school teacher who is also a user.

You see I do not need to be on queue to see the traditional health practitioners like in the hospitals, neither are my faced with the problem of language or difficulty in communicating my health problems to these herbal practitioners (Personal interview, 14/7/2013).

The need for the patient and the practitioner to share similar worldviews and language may also be a reason for continued utilization of herbal tonics. The above factors account for this inter-
cultural borrowing and also lead to increasing production and utilization of this south-western herbal remedy in south eastern Nigeria.

Production and Utilization of this South-western Nigeria Yoruba herbal remedy in South-Eastern Nigeria

The producers and distributors of agbo comprise both gender (few males and more females) and mostly migrants from western Nigeria but it is mostly sold, hawked and distributed by Yoruba women as narrated by this respondents.

The few men who sell do not carry theirs on the head to hawk like the way women carry processed agbo filled in bottles. They prefer to establish roots and herbal shops, where the raw materials are sold while some other male sellers who cannot afford shops, shred and package these roots and herbs and then move about advertizing it (Personal interview, male distributor 26/6/2013).

Those who buy from these men are taught immediately on the spot how to process the herbs, they are often told to pour the shredded herbs and roots in a container, add water, leave for at least a day after which, they can start drinking it (Personal interview, female producer 29/6/2013).

This finding agrees with the “do-it-yourself” description of alternative medicine as opined by West (1993 cited in Barry & Yuill, 2014, p. 56). Producers sell to mostly people of low socioeconomic status like labourers involved in daily hard work in timber shades, poor, and a few educated people who still think traditional drugs are more effective than biomedical drugs. The raw materials are gotten from a network of suppliers as narrated by this respondent:

Our business is to travel to western Nigeria to source for these herbs and roots from all parts of the Yoruba land and then transport them to eastern Nigeria from where the producers buy, process, sell and distribute to users (Personal interview, Female Supplier, 20/7/2013).

This study also found out that the utilization of herbal remedies by people in south eastern Nigeria is majorly to meet specific health needs, particularly gender-specific health needs. Agbo is used by all categories of people; it is used by men as ‘man-power’ or stimulants (when alcohol is used as solvent) and as cure for infections such as sexually transmitted infections (STIs) and by men suffering low sperm count among others.
Women use it mainly for fertility issues, menstrual problems and other ailments. Agbo is also used to treat children suffering from chicken pox, typhoid, measles, convulsion, purging/stool. Agbo is used for treatment of various sicknesses like waist/body pain, stomach problems (jedijedi), malaria, gonorrhea, infertility issues in women, among others (Personal interview, Mama agbo, 20/6/2014).

This implies that utilization of particular traditional herbal remedies could be gender and age specific. It then implies that one important distinction between alternative and biomedicine is the former’s ‘holistic emphasis’ (Barry & Yuill, p. 56). This could be a reason for increased utilization of herbal tonics in Nigeria but what are they implications of herbal drugs utilization in Nigeria?

**The implications of pragmatic acculturation in Nigeria**

There are health, political, religious, economic, and socio-cultural implications of pragmatic acculturation. Health wise, pragmatic acculturation poses both negative and positive implications. People who take most of these unscientifically produced and untested herbal tonics could arguably experience damages of vital organs such as kidney, heart, lungs, intestines, loss of sight, hearing, uncontrollable diarrhea/vomiting and in the process may lose their lives, among other health risks. People could also be rendered impotent and infertile because most traditional herbal tonics lack scientifically proven dosages in spite of the claims by practitioners. Socioeconomically, the low income earners seem to be more affected as they seem to be ignorant of the health consequences of some traditional herbs as shown by this respondent.

> My dear forget about that stuff, you school people often condemn everything about Africa, our forefathers used these herbs to cure sickness and they didn’t die. If you talk about dosage, we use a small cup to measure the herbs, one cup in the morning and evening before food (Personal interview, Mama agbo, 20/06/2013).

As rightly captured by Ajala and Omobowale, (2013, p. 149) “within the last twenty years or so, herbal remedies remain a complex issue affecting public health security in Nigeria. Among the challenges posed to public health by herbal remedies is the exclusive use of many of these herbal remedies among the people of low income”. The increasing utilization of traditional herbal remedies in the 21st century Nigeria has been attributed majorly to socioeconomic reasons.
According to Offiong (1999, p. 121) “most people cannot afford to see physicians, they therefore flock to traditional healers and spiritualities”.

Pragmatic acculturation is not totally negative. Positively, pragmatic acculturation creates alternatives and provides the health seeker with multiple options to make informed choice of preferred health system to utilize. Socio-culturally, pragmatic acculturation enhances cultural integration in pluralistic and multiethnic societies like Nigeria. It enhances mutual interdependence between hosts and settler/migrants. This encourages and engenders informal cultural exchanges and utilization of cultural knowledge, autochthonous herbal remedies, beliefs and practices among ethnics living within a society. Politically, it is arguably true that access to and provision of a quality care is first a political issue. It is politics that determines who gets what, where a particular health facility is sited and to some extent who can afford such health care. The continued persistence of production and utilization of herbal remedies among Nigerians in spite of some of its negative consequences reveal the inadequacy and failure in the Nigerian health care system. Most citizens of Nigeria cannot afford or access quality health care because they are expensive to low income earners and in some cases quality health care are not available particularly to grassroots residents.

**Discussion**

We have been able to x-ray *agbo* as a traditional herbal medicine in this study. Traditional herbal medicine can also be known as ‘native medicine’ and could be defined as a system of medicine that is autochthonous, non-conventional or non-western (Nnadi, 1984). However, as a result of pragmatic acculturation users can now make use of traditional herbal medicines that are not autochthonous to them. Though, every human group has its own health systems developed over centuries from resources within its environment and sustained with the knowledge from socio-cultural contexts and realities. Claims to acquisition and propagation of traditional herbal knowledge/skills by practitioners is often gained through apprenticeship under an experienced aged healer, others claim they gained such through inheritance, dreams, trance, among others (Chidili, 2012; Kanu, 2012). Traditional herbal medical practices in Nigeria are varied based on multi-cultural nature of the people. These traditional health systems have proved their worth among the people as they have been effective and efficient in keeping the people hale and hearty before the introduction of bio-medical health systems in Nigeria. Even with the introduction of
orthodox medicine, traditional herbal medicine still persists in spite of the fact that it has been branded as ‘unscientific’, people still identify with it as an aspect of the cultural heritage of the people. Traditional herbal medical currently occupies the health space in Nigeria as ‘alternative medicine’. This is adequately captured by Offiong (1999, p. 118) “in Nigeria as well as in other developing countries, scientific and traditional medicine coexist side by side and the two systems are patronized by health consumers, both complement each other”. So the question of whether both coexist in a single society/community may not arise and may no longer be an issue among scholars. Several factors give credence to this, one of which is the complementary role each play in satisfying the health needs of health consumers, others are the flexibility of both systems in accommodating each other and a more acceptable reason among respondents is the need for preservation of cultural values and heritages. Thus, Ogundele, (2007, p. 147) observed that ‘every human group likes to preserve its age-old ways of life without interference from any quarters. There is no substitute for sustainable development. Local systems, be they social, economic, and ecological are collective assets or cultural heritage of the group concerned’ and as such should be sustained.

**Conclusion**

Persistence of pragmatic acculturation remains a reality in modern global societies. This question the extent of the influence of globalization on local practices as some of these traditional practices continues to exist. This study has been able to show that change and cultural borrowing could be triggered by internal forces through internal pragmatic acculturation. Also, as observed by Quah, (2008, p. 420) “pragmatic acculturation can be used to understand macro-level healing systems and structures and also the micro-level health users and providers”. This study therefore argued that, sometimes internal or intra-city migrants could serve as health providers who at the same time initiate conscious cross-cultural borrowing, while the host advertently or inadvertently becomes the user. In some other cases the host becomes the introducer of a healing practice. This implies that the user-provider role/status could be interchanged depending on the need and context. Thus, in the words of Quah (2008, p. 420-421) “pragmatic acculturation takes place among users as well as providers but in different fashions and driven by different motivations”. Migrants therefore consciously carry along the knowledge and practice of their traditional herbal medicine to their new abode in order to meet specific health needs. This study has revealed that
there are specific health needs of the people that orthodox/modern medicine is not meeting, hence the persisting preference for alternative herbal medicine.

In sum, this study recommends a re-visitation of the primary health care policy, regulation of traditional herbal practitioners and proper health education of the Nigerian populace on the negative impacts of pragmatic acculturation on health.

References


